June 3, 2007

- ND MAMES providers questions for ND Medical Assistance, May 16, 2007. Compiled & edited by Greg Lord of Great Plains Rehab Services, 701-530-4000.
- NDMA RESPONSES IN THE BLUE
- RESPONSE FROM GROUP DISCUSSION IN GREEN
- IN ATTENDANCE: Barb Stockert (MeritCare HCA), Sheila Stenson (Altru Home Services), Pat Greenfield (MedQuest), Mitch Evenson (MedQuest), Jeri Geiger (CostCare), Pamela Pfaff (GPRS), Greg Long (GPRS), R. Nylander (HCA), Karen Tescher, Dan Johnson, Juli Johnson, Erik Elkins, Barb Fischer, Barb Koch, Mary Helmers (Medical Services)

1. COVERAGE VERIFICATION

   Would it be possible to verify coverage for a beneficiary if the family is in the process of obtaining a ND Medical Assistance number? Wouldn't coverage criteria be the same if the client had a Medical Assistance number or didn't? This way…HME providers would be able to inform the patient immediately about coverage & potential out-of-pocket expenses. Some items/areas are clearly defined, but some items are not…and that is where we would like to use this process.

Prior approval to provide services does not include determination of the client's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient eligibility on the date of service. When the recipient applies for Medicaid a number is assigned right away and a prior can be submitted but remember, if the prior is approved it is not a guarantee of the recipient's eligibility and you would be providing at your own risk before eligibility is confirmed.

DISCUSSION: When the recipient applies for MA at the county office a Medicaid ID number is assigned immediately. The DME provider can obtain the number from the recipient or the county Eligibility Worker and a PA can be submitted for an urgent review but only in very unique circumstances (i.e. Client is moving to North Dakota, had not been approved for ND Medicaid, and is in need of a ventilator, suction equipment, etc.). If such a review is necessary the provider would need to document on a cover letter the need for an urgent review, attach it to the PA with supporting documentation and send it to NDMA for review.

2. COVERAGE VERIFICATION

   Is there any way of HME Providers and ND Medical Assistance can work together to identify beneficiaries that are in "group homes" but must be billed as if they were in a skilled facility? The HME provider would like to determine this "location" question ahead of time. What question could the HME provider ask the facility that would indicate that ND Medical Assistance is to be billed that way? Can we ask what type of "Place of Service" are you listing on your claim for ---- a 31 or 32 OR are there other numbers that you consider being a MR facility and we need to follow different guidelines for receiving payments?

Providers need to ask the recipient or the facility the recipient resides in if it is an ICF/MR (Intermediate Care Facility for the Mentally Retarded) or a skilled nursing facility and indicate the appropriate response on the PA.

DISCUSSION: The DME Provider will need to clarify with the facility as to what type of facility the recipient resides as some facilities may be considered more than one type.

3. MEDICAL ASSISTANCE FORM

ND HME providers are requesting that ND Medical Assistance representatives bring a certain "form" to the meeting...the form ND Medical Assistance would like HME Providers to use to get HCPC codes added. Also, can we simply just send the Medicare update with the form…so we do not have to do any further research on the codes?

When Medicare adds a code to their fee schedule does not guarantee NDMA will add it to theirs. We review all new and updated codes and add them to the fee schedule if deemed appropriate. A prior can be submitted with a note on the cover letter to please consider adding to the price file and please attach documentation to support the request along with Medicare allowable. If new technology is requested then the Technology/Procedure Assessment Documentation (SFN 905) must be submitted.

DISCUSSION: If the HCPC code is considered similar to another already approved HCPC code then the provider can send a PA with a cover letter to indicate the need for NDMA to consider adding the HCPC code to the price file. Please provide the reason why NDMA should consider adding to the price file along with the Medicare allowable. If the request is for something very unique, an upgrade to an existing HCPC code, or is considered new technology, then the SFN 905 would need to be submitted. If the request is for an item similar to an item we currently cover but would have significant financial impact then the SFN 905 would also need to be submitted.

4. PRIOR AUTHORIZATION

Can the amount of time for requesting a prior authorization (within 90 days) be changed from date of service (DOS) to the "denial date?" The rationale for this request is that currently it is taking approximately 120 days to have a ND Medical Assistance claim processed. If a claim comes back to an HME provider because it needed a prior authorization, the HME provider is already behind the timeline because the claim had not processed within 90 days. This date should be consistent with the ND Medical Assistance denial date so HME providers are given an adequate chance to obtain a prior authorization. Incidentally, MN Medical Assistance allows one year from the DOS to get a prior authorization.

The DME fee schedule clearly identifies codes that require prior authorization and this should be obtained before the product is dispensed. Point being: Even if Medicaid is the secondary payer a PA must be submitted for review. Why would you wait until the claim denies for prior auth?

The operative word being "prior".

DISCUSSION: NDMA's stance is firm on this matter.

5. MANUFACTURER'S INVOICE

This is a question about "miscellaneous codes." Providers have received denials asking for the invoice. What invoice is ND Medical Assistance looking for? When a HME provider submits a prior authorization request, the HME provider may not have an invoice from the manufacturer…because typically, the HME provider does not order product until after the prior authorization request has been approved. Would a quote from the product manufacturer be acceptable?

A quote from the manufacturer will work but when the claim is submitted the original invoice must accompany the claim.

DISCUSSION: Decided by the group that the quote is acceptable for the prior authorization but a copy of the original invoice will need to be attached to the claim when the claim is submitted.

6. SUPPLY QUANTITIES

This is a question about supply "quantities" listed on orders. HME providers receive denials because the ordering physician does not list the supply quantity. If the item already has quantity limits set by ND Medical Assistance…why does this information need to be on the physician order? Most physicians will tell us "I don't know" the quantity a patient will require in a month…they will just specify "a month supply" and ask the HME provider to "get the patient what they need." Again, if there are quantity limits set by ND Medical Assistance on any particular supply, HME providers are prepared to provide that amount or less depending on the needs of the patient.

We are responsible for utilization management. A Physician should be talking with their patient's as the physician is also responsible to help with utilization management. This is a team approach. Wouldn't you expect a quantity prescribed for medication? An Rx, is an Rx, is an Rx.

DISCUSSION: NDMA stands firm on this matter.

7. MAINTENANCE REIMBURSMENT

A prior authorization request was sent to ND Medical Assistance for CPAP Maintenance on a piece of customer owned equipment. The prior authorization request was denied because "previous maintenance to be taught to the client at time of purchase." The HME providers' staff does not only check & change filters…but test equipment to check the CM H20 (which is a manufacturer requirement). This testing cannot be done by beneficiary as it requires special testing equipment that cost HME providers about $650 per testing unit. Also, this kind of testing should not be performed by beneficiaries because of the complexity of the testing procedure, nor is it feasible for ND Medical Assistance to purchase the $650 testing equipment for all beneficiaries that obtain CPAP's. Can the reimbursement for this testing be reconsidered?

We only reimburse Service and Maintenance for O2 equipment. How do you handle this situation with private pay individuals? Do you bill them? What do other State Medicaid Agencies do?

DISCUSSION: NDMA requested the DME providers to submit documentation as to how and/or if other State Medicaid Agencies reimburse for service and maintenance of capped rental equipment. NDMA currently pays for necessary repairs and labor for patient owned equipment that is not under a warranty period.

8. SUPPLY COVERAGE

At present, gloves are only covered when a beneficiary is incontinent of feces. Some beneficiaries require sterile catheterization several times a day. It seems to be a contamination/hygienic/efficacy issue. Can coverage be reconsidered?

We have never covered sterile gloves. If recipients are self cathing this frequent they are most likely using clean technique and not sterile.

DISCUSSION: Informed by the Providers that sterile gloves are included in the sterile catheter kits and that this should not be an issue.

9. LABOR REIMBURSEMENT

Labor is not covered on beneficiary owned equipment…unless parts are purchased at the same time. In many incidences, HME provider service technicians are called out at all hours to service equipment…sometimes traveling many miles. How can ND Medical Assistance expect HME providers provide repair to beneficiary owned product with no reimbursement? Many times power chairs require adjusting/altering/correcting/slicing to make it operational. Why wouldn't these repair situations be covered? A person wouldn't expect an appliance repair person to come to their home, repair an appliance and leave with no charge if no replacement parts were involved. HME providers believe that this

ND Medical Assistance policy is short-sighted and has not been a thoroughly appraised. Can the reimbursement for service be reconsidered?

Why are recipients not bringing the equipment into your facility for repairs if the equipment size and weight permits? Labor for growth adjustment to wheelchairs and standing frames is an allowable cost as well as labor involved for wiring issues to wheelchairs. Documentation must support the request. Minor labor is considered included in the purchase agreement and not allowed unless parts are billed. Recipients should be taught how to care for their equipment. We have discovered that we are paying labor for repairs to equipment under warranty.

DISCUSSION: Minor repair and upkeep of equipment needs to be taught to the recipient and/or their caregiver(s)

10. LABOR REIMBURSEMENT

It is the HME providers understanding that it is ND Medical Assistance policy that no service reimbursement is allowed until equipment is owned for one year. HME providers understand that many parts are covered under warranty but labor is not. Why should HME providers be required to absorb the cost of labor when servicing a piece of equipment that is not working properly? Even Medicare considers this and covers this cost to the provider

If the equipment is under warranty the issue of labor reimbursement should be taken up with the manufacturer. Please provide me with documentation that Medicare will cover labor if equipment is under warranty.

DISCUSSION: NDMA has requested the DME providers submit documentation as to how and/or if other State Medicaid Agencies will reimburse for labor only and if so in what circumstances.

Barb Stockert has submitted Medicare information to show that payment will no longer be made every six months for maintenance and servicing for capped rental equipment by Medicare. Once the patient owns the equipment, however, Medicare will cover reasonable and necessary repairs and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) which was put into effect January 1, 2006. Per Medicare guideline as well, effective January 1, 2006, payment may be made for maintenance and servicing of oxygen equipment every six months, beginning six months after the beneficiary owns the equipment (after the 36th month of rental the beneficiary will own the equipment).

NDMA also covers service and maintenance every 6 months for recipient owned oxygen equipment, beginning six months after the recipient owns the equipment. This service requires prior authorization. NDMA also allows reasonable and necessary repairs and labor for capped rental items that are recipient owned and not under any warranty period. If the equipment is under warranty the manufacturer is responsible for parts and labor.

11. BILLING IN SNF

HME providers are required by Medicare regulation to bill the beneficiary the remaining 20% of the allowed amount on Medicare covered items. When we provide a covered item to a beneficiary in a Skilled Nursing Facility (SNF) ND Medical Assistance will not allow separate reimbursement for these items because they are included in the "per diem" to the facility. The majority of the customers HME providers service in facilities have ND Medical Assistance as their secondary payer. What our HME provider options in these situations? HME providers are not allowed to bill the facility. ND Medical Assistance has previously told HME providers that it is their decision/payment is considered final because you are the last payer of record. HME providers are mandated by Medicare regulation not to waive these co-pays to help reduce fraud in the Medicare program, the Office of Inspector General is actively investigating health care providers, practitioners and suppliers of health care items and services who (1) are paid on the

basis of charges and (2) routinely waive (do not bill) Medicare deductible and co-payment charges to beneficiaries for items and services covered by the Medicare program. A provider, practitioner or supplier who routinely waives Medicare co-payments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is $100, but routinely waives the co-payment, the actual charge is $80. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the supplier's misrepresentation, the Medicare program is paying $16 more than it should for this item. A provider, practitioner or supplier who routinely waives Medicare co-payments or deductibles could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). What Penalties Can Someone Be Subject to for Routinely Waiving Medicare Co-payments or Deductibles? Whoever submits a false claim to the Medicare program (for example, a claim misrepresents an actual charge) may be subject to criminal, civil or administrative liability for making false statements and/or submitting false claims to the Government. 18 U.S.C. 287 and 1001; 31 U.S.C. 3729; 42 CFR 1320a-7a). Penalties can include imprisonment, criminal fines, civil damages and forfeitures, civil monetary penalties and exclusion from Medicare and the State health care programs. In addition, anyone who routinely waives co-payments or deductibles can be criminally prosecuted under 42 U.S.C. 1320a-7b(b), and excluded from participating in Medicare and the State health care programs under the anti-kickback statute. 42 U.S.C. 1320a-7(b)(7). Finally, anyone who furnishes items or services to patient substantially in excess of the needs of such patients can be excluded from Medicare and the State health care programs. 42 U.S.C. 1320a- 7(b)(6)(B).

We will turn this issue over to our legal department to review.

Appendix D of the DME manual outlines items to be supplied by facility and not payable to pharmacies or other suppliers.

Items allowed for separate payment if resident is a SNF include: Hearing aids, orthotics, shoes for diabetics, customized shoes, and custom seating systems for recipient owned equipment, prosthetics, repairs to recipient owned equipment, specialized beds or mattresses costing $25 or more per day, vacuum assisted wound closure system, and ventilators.

DISCUSSION: Will respond to Providers after the Legal Department has reviewed and prepared a response.

12. HME PROVIDERS COST OF DOING BUSINESS

HME providers receive from ND Medical Assistance the lowest percentage payment, highest percent of nonpayment, highest percent of write-offs, the most unpaid claims, and the slowest claim processing than any state Medical Assistance or other third party payor. With the North Dakota State government operating substantially in the black, why are HME providers paid so poorly and so slowly. Is there something that can be done in ND Medical Assistance to work proactively with MAMES to receive an adequate rate of reimbursement and be reimbursed in a more timely fashion?

Where did your statistics come from? The claims are processed oldest to newest date received. If a claim suspends all providers claims are processed accordingly. JJ

Inflationary or other reimbursement adjustments are provided in accordance with the appropriation provided by the Legislature. For the 2007-2009, the Legislature authorized a 4% increase on 7-1-07 and 5% on 7-1-08. Outside of these increases, there was no extra appropriation for Durable Medical Equipment. MA

DISCUSSION: Claims are worked in the order received. Much discussion was held regarding claims in suspense as well as Medicare crossover claims. NDMA reassured providers that we are working very diligently to handle this matter. Temporary staff has been hired to help out.

Providers were informed of inflationary adjustments and that they are provided in accordance with the appropriation provided by the Legislature. Issues of reimbursement over and above the appropriation will need to be addressed with the Legislature by the DME providers.

13. PHYSICIAN ORDERS

    It seems to be a duplication of work to have the physician sign both the CMN and the prior request. Is it possible to do one or the other?

We have not required a physician signature on both forms. One or the other is fine.

DISCUSSION: A signature is required on the PA or the CMN. Not required on both forms.

14. PRIOR AUTHORIZATION

    If the quantity prior authorized per month fluctuates for a month or so, how do HME providers indicate this fluctuation on a claim or do HME providers need to re-prior?

If you have not received a prior back within 3 weeks from the fax date then the Provider can refax the prior or call provider relations to check the status as the prior may have been adjudicated and entered recently and you have not received the prior yet. Some Providers have had their own internal problems with receiving priors. Please check with your facility as to where the priors are received and how they are routed.

DISCUSSION: No further discussion

15. APNEA MONITOR FORM

    Suggestion - On the Apnea monitor form would it work better to change the form and offer a selection of ranges, i.e. 5 to 10 - 10 to 20, for the number of episodes….rather than and exact number?

We can consider this? Review with Providers.

DISCUSSION: NDMA will update the form but until then the Providers can write in the range if they choose. The update to SFN 528 has been submitted with the requested change. When the change has been completed the new form will be available on the department website under e-forms.